

The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) offers states the option to implement the Basic Health Program (BHP). BHP gives states 95 percent of what the federal government would have spent on tax credits and subsidies for out-of-pocket costs for two groups:

- Adults with income between 133 and 200 percent of the federal poverty level (FPL); and
- Legally resident immigrants with incomes below 133 percent FPL whose immigration status disqualifies them from federally matched Medicaid.

If a state implements BHP, these two groups of consumers cannot receive subsidized insurance in the exchange. Instead, the state covers them by contracting with health plans or providers. Such contracts must provide at least the minimum essential benefits under ACA, and consumers may not be charged more than what they would have paid in the exchange.

Rather than analyze the full range of state options for implementing BHP, this paper focuses on strategies that reduce health care costs for low-income residents. Of course, ACA's tax credits and other subsidies will make coverage much more affordable to the uninsured, but research suggests that the amounts charged in the exchange could still deter many low-income consumers from signing up for coverage. A further deterrent to enrollment could be consumers' fear of owing money to the Internal Revenue Service at the end of the year if their annual income turns out to exceed what consumers anticipated when health insurance tax credits were paid during the course of the year. Finally, among some low-income adults who sign up for coverage, out-of-pocket costs could delay or prevent utilization of necessary care.

The BHP option permits states to sidestep these obstacles by giving low-income residents "Medicaid look-alike" coverage or "CHIP [Children's Health Insurance Program] for adults," with lower consumer costs than will be charged in the exchange and without any risk of beneficiaries incurring year-end tax debts. In many, if not most, states, the federal government would pay all the costs of such coverage. Primarily because provider payments are higher with private insurance than with Medicaid, federal BHP payments are projected to exceed by 29 percent what it would cost Medicaid to cover BHP-eligible adults in the average state.

This projection assumes that plans in health insurance exchanges will charge premiums like those in current private markets. If premiums in the exchange—hence, tax credits—exceed anticipated levels, then federal BHP payments will be higher than the amounts estimated here. Conversely, if premiums are lower than expected—for example, if an exchange obtains low premium bids, or inexpensive Medicaid plans join an exchange and cause tax credits to be set at low levels—then federal BHP funding will fall below projected levels.

Notwithstanding these factors, if premiums in the exchange are similar to those charged by today's insurers, a state may be able to integrate BHP, Medicaid, and CHIP into a single, rebranded program serving all uninsured residents with incomes up to 200 percent FPL. Although cost-sharing could rise modestly as income increased above 133 percent FPL, the same health plans would provide coverage so long as income remained below 200 percent FPL, thus improving continuity of care. In addition, if "safety net" plans with a history of operating in low-income communities do not offer coverage through the exchange, they could nevertheless continue serving low-income consumers when incomes rise above Medicaid levels.

This approach would let states save money by eliminating optional Medicaid eligibility for adults above 133 percent FPL, who include pregnant women in most states. Of course, states could achieve the same savings by ending Medicaid for adults above 133 percent FPL and moving them into the exchange. But BHP could give the state equivalent savings without increasing costs or reducing benefits for currently eligible, low-income adults.

From the consumer's perspective, a serious disadvantage of this "Medicaid/CHIP lookalike" approach to BHP is that, in most states, provider payment—hence, the breadth of provider networks—would be lower than in the exchange. However, if federal BHP payments to states exceed baseline Medicaid costs, BHP provider reimbursement could likewise exceed Medicaid amounts. As with many CHIP programs, provider participation could fall between Medicaid and private levels.

Another strategy for BHP implementation would let consumers choose between Medicaid plans and subsidized coverage in the exchange. Such a "two-way" bridge between public programs and the exchange would promote continuity of coverage and consumer flexibility. However, plan choices could be overwhelming to many consumers, and states would need to guard against adverse selection and compensate plans for the difference between BHP payments and subsidies in the exchange.

From the state's perspective, implementing BHP using any of these approaches will have the disadvantage of reducing the size of the exchange. Instead of covering 8 percent of non-elderly residents, the average state's individual market in the exchange would serve 6 percent. As a result, the proportion of residents receiving either individual or group coverage through the exchange would decline from 16 to 14 percent. Such reductions are unlikely

to threaten exchange viability, but they would decrease the number of participants among whom exchanges spread fixed administrative costs.

BHP implementation could affect the average risk level of the remaining individual enrollees in the exchange, but the net effect will probably be modest in most states. ACA requires insurers to pool all customers in the individual market, inside and outside the exchange. If ACA's insurance rules work as intended, BHP implementation will change risk levels in the entire individual market. As a result, the impact on average costs will be less than if BHP's effects were limited to the exchange.

That impact might be eliminated entirely if the U.S. Department of Health and Human Services (HHS) permits states to adopt policies requiring BHP plans to share risk with insurers offering individual coverage. Under this approach, a state-licensed insurer that participates in BHP would pool its BHP members with its other individual enrollees. And whether or not a BHP plan is sponsored by a state-licensed insurer, it would participate in state-administered risk-adjustment and reinsurance mechanisms. If HHS allows such policies and they succeed, BHP implementation would simply shift enrollees among plans that share risk, without changing average costs per consumer.

A full analysis of BHP implementation along the lines described here requires state-specific information, building on the national estimates presented in this paper. Further, federal authorities have not yet settled important questions about the meaning of relevant ACA provisions. And, without doubt, some states will pursue approaches to BHP that differ greatly from the general directions described here. That said, for state officials interested in improving affordability and continuity of coverage for low-income residents while maximizing state budget savings, using BHP to build on the existing infrastructure of Medicaid and CHIP is an option that deserves serious consideration.

Introduction

The Patient Protection and Affordable Care Act (ACA) offers states the option to implement the Basic Health Program (BHP) for low-income residents who are ineligible for Medicaid. This paper describes ACA's rules for BHP, explores selected approaches that states could take to implement BHP, and analyzes key issues that such approaches would raise for consumers and states.

What is the Basic Health Program?

Structure and federal funding

In a state that implements BHP, eligible consumers may not obtain subsidized coverage in the exchange. Instead, they are covered through state contracts with health plans or providers. To support these contracts, the state receives 95 percent of what the federal government would have spent if BHP enrollees had received tax credits and subsidies for out-of-pocket (OOP) costs in the exchange. The federal dollars are placed in a state trust fund and may be used only “to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in” BHP.¹ The U.S. Department of Health and Human Services (HHS) makes one BHP payment to a state before a federal fiscal year begins, based on the best available projections. If the amount turns out to be too high or too low, HHS makes an offsetting correction in the next year's payment. Although the issue has not been resolved by HHS, it seems likely that federal BHP funds may be used to pay BHP administrative costs.²

Eligibility

To qualify for BHP, consumers must have the following characteristics:³

- They are U.S. citizens or lawfully present immigrants under age 65;
- Their income does not exceed 200 percent of the federal poverty level (FPL);⁴

- They do not qualify for coverage available through Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); and
- They are not offered employer-sponsored insurance (ESI) that meets ACA's standards for affordability and comprehensiveness.⁵

BHP thus covers two distinct groups of otherwise uninsured consumers:

- Adults⁶ with Modified Adjusted Gross Incomes (MAGI) between 133 and 200 percent FPL; and
- People with incomes at or below 133 percent FPL who are ineligible for federally matched Medicaid because of immigration status—for example, because they were granted status as lawful residents within the past five years.⁷

If Congress fails to fund federal CHIP allotments beyond 2015, a third group might also qualify for BHP—namely, children with incomes between 133 and 200 percent FPL who would have received CHIP if federal allotments had continued. Without BHP, such children could presumably go into the exchange,⁸ much like adults in the same income range.

Coverage

To implement BHP, a state uses a competitive process to contract with health plans or provider groups that meet the following requirements:

- All minimum essential benefits under ACA are covered.
- The BHP consumer is not charged premiums that exceed what the consumer would pay in the exchange.⁹
- The consumer receives coverage with an actuarial value that meets or exceeds certain minimum thresholds.¹⁰
- The plan is either a “managed care system ...” or a “system ... that offer[s] as many

of the attributes of managed care as are feasible in the local health care market.”¹¹ This provision does not require the state to contract with a risk-bearing insurer, however. For example, states could implement a form of managed care that is common in Medicaid, which combines fee-for-service reimbursement with “primary care case managers” who receive monthly payments for coordinating care.¹²

- The state negotiates to have the plan or provider implement innovations that include “care coordination and care management,” “incentives for use of preventive services,” and efforts to “maximize patient involvement in health care decision-making” combined with “incentives for appropriate utilization.”¹³

“To the maximum extent feasible,” the consumer is offered a choice of plan options.¹⁴

- If it is operated by an insurer:
 - The plan must report on state-selected performance measures that focus on quality of care and improved health outcomes, sharing results with consumers and the state; and
 - The plan's medical loss ratio—that is, the proportion of premium payments that go to health care and quality improvement rather than to administration—may not fall below 85 percent.

How states can use BHP to make coverage more affordable for low-income residents

As the previous section makes clear, the BHP option gives states considerable flexibility to design coverage for their low-income residents in ways that depart from some of ACA's national rules. States could thus use the option to realize, with the

Table 1. Minimum premium costs and the actuarial value of coverage for a single, uninsured adult at various income levels qualifying for subsidies under ACA

Percentage of FPL	Monthly Pre-Tax Income	Minimum Monthly Premium	Actuarial Value
150	\$1,354	\$54.15	94%
175	\$1,579	\$81.34	87%
200	\$1,805	\$113.72	87%
225	\$2,031	\$145.70	73%
250	\$2,256	\$181.63	73%

Notes: Dollar amounts assume 2010 FPL levels. If future FPL levels rise per Congressional Budget Office projections of increases to the Consumer Price Index¹⁵, monthly pre-tax income and minimum monthly premiums in 2014 will be 6.4 percent higher than the amounts shown here. Actuarial value represents the average percentage of covered health care services paid by the insurer, taking into account deductibles, copayments, and co-insurance.

BHP population, many different visions for covering the low-income uninsured.

This paper does not explore the full range of possible approaches to BHP. Rather, it focuses narrowly on policies that, without spending any state funds, make low-income consumers' coverage significantly more affordable than subsidized insurance in the exchange. After describing key affordability issues, this section explains why, in most states, federal BHP dollars could exceed Medicaid costs for BHP adults. It then shows how states could use BHP to improve the affordability of coverage and care for low-income residents without spending state dollars. It concludes by exploring trade-offs that consumers would face under these approaches.

Affordability of subsidized coverage in the exchange

Subsidy levels and limits

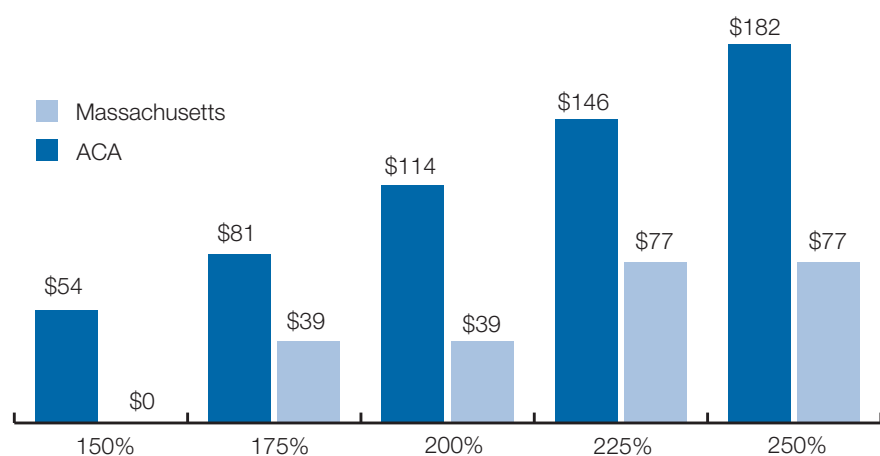
Without BHP in place, low-income subsidy recipients with incomes too high to qualify for Medicaid will make premium payments

in the exchange and qualify for coverage with the actuarial values shown in Table 1.

Low-income consumers' premium payments are likely to increase slowly after 2014. Beginning in 2015, ACA caps premium subsidies to increase no faster than personal income, which has historically risen more slowly than health insurance premiums.¹⁶ If that pattern continues, subsidy recipients in the exchange will experience small annual increases in the percentage of household income required for premium payments.

An additional limit on premium tax credits involves year-end reconciliation with the Internal Revenue Service (IRS). If credits provided during the year turn out to be too low, based on annual income reflected on federal tax returns, consumers receive a refund. But if tax credits are too high, beneficiaries must repay the excess, up to a "safe harbor" maximum that varies by income—\$600 for a family at or below 200 percent FPL, \$1,000 between 200 and 250 percent FPL, and so forth.¹⁷

Figure 1. Minimum monthly premium payments for a single adult at various FPL levels, 2010: ACA versus Massachusetts CommCare



Source: Massachusetts Commonwealth Connector 2010.²¹

Moving from premiums to OOP costs, actuarial value (AV) refers to the percentage of health care costs that an insurer pays for an average population by offering specific covered benefits, copayments, deductibles, co-insurance, and limits on OOP costs. Many combinations of cost-sharing rules and benefits fit each AV, complicating efforts to analyze the affordability of OOP costs for low-income consumers under ACA.

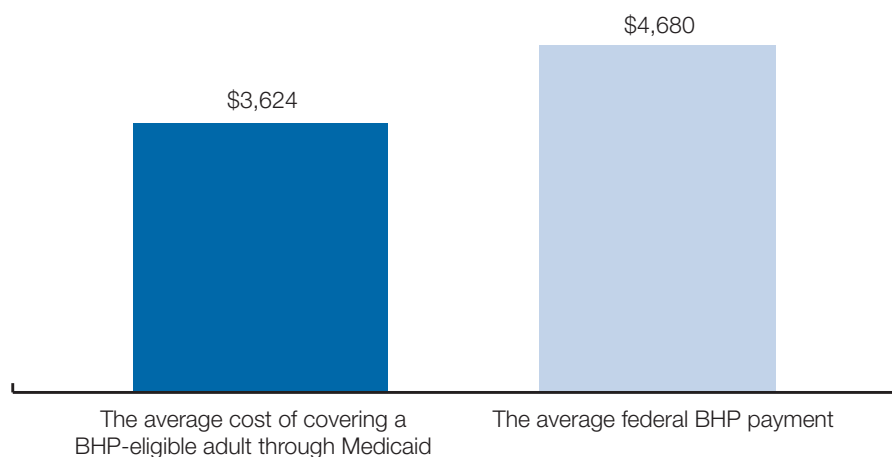
One potentially fruitful approach looks at examples of coverage at applicable AV levels. According to the Congressional Research Service (CRS),¹⁸ the typical, employer-sponsored Health Maintenance Organization has an AV of 93 percent, which is approximately the AV for adults in the exchange with incomes at or below 150 percent FPL. Such a plan has:

- No annual deductible;
- \$20 office visit co-payments;
- A \$250 co-payment for inpatient hospitalization; and
- Prescription drug co-payments of \$10, \$25, and \$45 for generic, preferred name-brand, and non-preferred name-brand drugs, respectively.

At the AV level for consumers with incomes between 150 and 200 percent FPL, the federal Blue Cross/Blue Shield plan has an AV of 87 percent, according to CRS, with coverage that involves:

- A \$250 annual deductible;
- \$15 office visit co-payments;
- A \$100 co-payment for inpatient hospitalization, plus a requirement to pay 10 percent of all remaining hospital costs;
- A requirement to pay 10 percent of all laboratory and X-ray costs; and
- A requirement to pay 25 percent of all prescription drug costs.

Figure 2. BHP federal payments versus the cost to cover BHP members through Medicaid: national averages



Source: Health Insurance Policy Simulation Model (HIPSM) 2011. Notes: These results show what would happen if ACA were fully implemented in 2010, with small employer and individual coverage merged into a single market. BHP payments would still exceed Medicaid costs, though by a smaller margin, if the two markets remained separate. Medicaid costs include both federal and state dollars and take into account the risk profile of BHP members. The average federal BHP payment equals 95 percent of what the federal government would pay in tax credits and OOP cost-sharing subsidies if BHP consumers had received coverage in the exchange.

Potential effects on consumers

To some degree, it is a matter of opinion whether these premiums and OOP costs exceed what low-income consumers can afford. However, two facts are not in dispute:

- ACA's subsidies will make coverage and care substantially more affordable for low-income adults who lack access to ESI; but
- In the past, premium and OOP costs such as those imposed by ACA have deterred many low-income consumers from enrolling into coverage and from using necessary care, sometimes with adverse effects on health status.¹⁹

Prior research showing the effects of premiums on low-income consumers' enrollment took place without any legal requirement to purchase coverage, which will increase participation. As with ACA, the 2006 Massachusetts reform law imposed such a requirement, which helped reduce the percentage of uninsured residents to the lowest level ever observed in any state.²⁰ But consumers' premium costs in Massachusetts's subsidized Commonwealth Care (CommCare) program were less than what will be charged in the exchange under ACA, as Figure 1 illustrates. Premium costs under ACA may thus lead to enrollment levels that are lower than those in Massachusetts, notwithstanding ACA's requirement to purchase coverage.

As noted earlier, ACA exempts preventive services from point-of-service cost-sharing. Accordingly, cost-sharing in the exchange may prevent some consumers from seeking treatment for illness, injury, or other health problems, but it should not affect check-ups, immunizations, and screenings.

Some low-income consumers may be deterred from seeking tax credits during the year because year-end reconciliation could endanger tax refunds or require payments to IRS that many low-income people might view as unaffordable. Such reconciliation is one reason that no more than 3 percent of low-income workers who receive Earned Income Tax Credits claim those credits during the year, in advance of filing year-end returns.²² Put simply, the combination of limited subsidies in the exchange and the potential for adverse tax consequences could reduce the gains in coverage and access that low-income consumers would otherwise experience under ACA.

Federal BHP payments and state costs

A starting point for thinking about how BHP could make coverage more affordable for low-income residents without spending state money is that, in many states, federal BHP payments are likely to exceed Medicaid costs (including both

state and federal shares). Mainly because of low Medicaid reimbursement rates for providers, private insurance is significantly more expensive than Medicaid, according to research that takes into account health status.²³ For example, among working adults, private insurance premiums exceed Medicaid costs by an average of 29.5 percent. It thus comes as no surprise that, according to the Urban Institute's microsimulation modeling of ACA,²⁴ average federal BHP payments, based on the cost of subsidies for private insurance in the exchange, will exceed by 29 percent what it would cost Medicaid to cover BHP-eligible individuals (Figure 2).

The differential shown in Figure 2 reflects more than low Medicaid provider payments, however. BHP adults, who tend to be young, will have higher premiums in the exchange (hence, higher BHP payments) than is warranted by their health care claims. With modified community rating, ACA permits the oldest adults to be charged no more than three times what the youngest adults pay for the same coverage, even though their health care costs vary by more than that ratio.²⁵

Figure 2's comparison between BHP payments and Medicaid costs assumes that plans offered in the exchange charge premiums generally typical of today's private insurance.²⁶ Tax credits (hence, BHP payments) are pegged to the premium charged for the second-lowest-cost plan at the "silver" level, which involves a 70 percent AV. If such a reference plan is more costly than what would be expected in today's private markets, federal premium subsidies (hence, BHP payments) will rise above the amount shown in Figure 2. If the reference plan is less expensive, BHP payments will fall below projected levels; such a reduction could occur if, for example, a Medicaid-based plan that charges very low premiums becomes the reference plan²⁷ or the exchange obtains surprisingly low bids from participating insurers.²⁸ **Accordingly, how a state operates its exchange could greatly affect federal BHP payments.**

Moreover, federal BHP payments will probably decline slowly over time relative to health care costs. BHP payments are based on the tax credits for premiums and OOP cost-sharing subsidies that BHP members would have received in the exchange. After 2014, premium tax credits will be indexed to changes in annual income,²⁹ which historically has grown more slowly than Medicaid costs. On the other hand, ACA's subsidies for OOP costs are not limited by indexing. As a result, BHP payments, which reflect both premium tax credits and OOP cost-sharing subsidies, will decline—relative to projected Medicaid spending—more slowly than tax credits alone. **If trends from 2000 through 2007 continue, a state with federal BHP payments and Medicaid costs like those shown in Figure 2 would see its BHP payments continue to exceed Medicaid costs for more than 25 years.**³⁰

Possible approaches to BHP implementation

States could use federal BHP resources in several ways to make coverage more affordable for low-income residents. Examples follow:

Using BHP to furnish more affordable coverage without building on existing public programs. A state might negotiate with private insurers to provide benefits like those offered in the exchange but with lower premiums and OOP cost-sharing. The precise approach would depend on policymakers' goals. For example, some states might give beneficiaries financial incentives to join programs that address obesity, tobacco use, and substance abuse; other states might cover translation services, transportation, and case management that connects beneficiaries to social services.

One disadvantage is that developing a new program requires administrative resources. After years of serious budget problems, many states will find it difficult to do even the minimum amount required to implement ACA, without designing and implementing a new, state-run program for low-income adults. In future years, creating such a program may be more feasible, but, in the

short term, it is probably be more realistic for most states to adopt one of the approaches described next, each of which builds on existing programs rather than creates a new system from scratch.

*Using BHP to provide “Medicaid look-alike” coverage.*³¹ BHP consumers enroll in the same managed care organizations that already contract with Medicaid.³² BHP consumers receive the benefits and cost-sharing protections that apply to Medicaid, even though applicable federal rules and funding arrangements differ.

Using BHP to fund a separate program styled as “CHIP for adults.” A state could raise cost-sharing slightly above Medicaid levels for consumers with incomes between 133 and 200 percent FPL. If a separate CHIP program is opened up to serve low-income parents and other adults, OOP costs will typically be lower than charges in the exchange, and covered benefits might be more generous. Provider payment could also rise above Medicaid levels, particularly if federal BHP payments exceed Medicaid costs.

A state taking this approach could experiment with innovations such as value-based insurance design and cost-sharing that gives consumers incentives to use more efficient providers.³³ Similar initiatives could apply in CHIP to create a single system of innovative coverage serving both adults and children with incomes too high for Medicaid but too low to easily afford subsidized coverage in the exchange.

Combining funding from BHP, Medicaid, and CHIP into a single, integrated program that serves all low-income residents. ACA does not require all BHP members to receive the same benefits and cost-sharing protections or to use the same provider networks. A state could thus operate a program with the following characteristics, shown in Table 2:

- The program serves all otherwise uninsured³⁴ state residents with incomes up to 200 percent FPL.
- A single set of health plans provides coverage. Benefits could either be the same for all enrollees or grow more limited as income rises.

- For consumers with incomes above 133 percent FPL:
 - Cost-sharing may increase above Medicaid levels, though the amounts would still be far below what is charged in the exchange; and
 - Provider payment levels may likewise increase, particularly if federal BHP payments exceed otherwise applicable Medicaid costs.
- Federal funding varies by enrollee:
 - Below 133 percent FPL:
 - Medicaid matching funds pay for citizens and most lawfully resident immigrants, with enhanced payments for newly eligible adults; but
 - BHP pays all costs for lawfully resident immigrants who do not qualify for federally matched Medicaid.
 - Above 133 percent FPL:
 - The federal government entirely funds adults' coverage through BHP;
 - Medicaid or CHIP pays standard matching rates for children who qualify for those programs; and
 - BHP pays for any children ineligible for Medicaid and CHIP.

Differences between Medicaid, CHIP, and BHP would primarily be a matter of “back room” accounting to maximize federal funding.³⁵ From the consumer's perspective, a single program would provide coverage so long as income does not exceed 200 percent FPL. Officials in Connecticut have proposed a similar strategy.³⁶

A state pursuing such an approach could “rebrand” low-income coverage to increase its appeal to consumers, the general public, and policymakers. Many states took similar steps in the late 1990s when they implemented CHIP by combining federal CHIP and Medicaid funds into a

Table 2. Combining BHP, Medicaid, and CHIP into a single program serving low-income, uninsured residents: one illustrative policy, 2014

Income, citizenship, and immigration status	Federal Funding			Benefits	Cost-Sharing	Provider Payment
	Adults Newly Eligible for Medicaid	Children Meeting CHIP's Age and Income Requirements	Other Adults and Children			
0 to 133 percent FPL				Medicaid		
Citizens	100% Medicaid match	Traditional CHIP match	Traditional Medicaid match			
Immigration status qualifies for federally matched Medicaid/CHIP	100% Medicaid match	Traditional CHIP match	Traditional Medicaid match			
Legally resident immigrants ineligible for federally matched Medicaid/CHIP	n/a	100% BHP payment	100% BHP payment			
134 to 200 percent FPL				For children: CHIP For adults: Comparable to CHIP		
Citizens	n/a	Traditional CHIP match	100% BHP payment			
Immigration status qualifies for federally matched Medicaid/CHIP	n/a	Traditional CHIP match	100% BHP payment			
Legally resident immigrants ineligible for federally matched Medicaid/CHIP	n/a	100% BHP payment	100% BHP payment			

Notes: After 2016, adults newly eligible for Medicaid will receive less than 100 percent federal funding. That percentage will gradually decline to 90 percent in 2020 and subsequent years. At some point after 2015, some CHIP-eligible children above 133 percent FPL may receive 100 percent BHP payments if Congress fails to provide new CHIP allotments. "n/a" in a cell indicates that the row includes no adults who are newly eligible for Medicaid.

single program that served all low-income children.

Using BHP as a two-way bridge between Medicaid and the exchange. A state could offer BHP consumers a choice between Medicaid look-alike coverage and subsidized plans in the exchange. A state pursuing this strategy would need to require plans in the exchange to offer identical coverage in BHP. Because such plans would need to discount their premiums by 5 percent, a state taking this approach might let insurers compensate for BHP premium shortfalls by slightly increasing the premiums they charge in the exchange.³⁷

Such a policy would have the advantage of letting each BHP consumer decide which factor is more important, given his or her circumstances: the greater affordability of Medicaid or the broader provider networks likely to be available in the exchange. This approach would also promote continuity of

coverage and care. If a Medicaid consumer's income rose above 133 percent FPL, the consumer could stay in a Medicaid plan; if an exchange participant's income fell below 200 percent FPL, he or she could remain in the exchange plan.

On the other hand, such a two-way bridge could confuse consumers by requiring them to sort through a large number of plans and two highly dissimilar subsidy systems. It could also raise concerns about destabilizing spikes in health care claims and risk segmentation, as the number of BHP enrollees in any particular plan could be quite small, and BHP consumers might sort themselves into Medicaid and exchange plans differently, depending on their health status. As a result, this approach would require effective policies that pool BHP risk with broader markets, as discussed below.

Trade-offs for consumers

The strategies described in the previous section could reduce premiums and OOP costs below levels charged to low-income consumers in the exchange; provide more generous benefits than those offered in the exchange (including some tailoring of service delivery to meet the special needs of low-income populations); and avoid any risk of consumers losing year-end tax refunds or owing money to the IRS.³⁸ Such approaches could also increase the number of families whose members can all join one program rather than enrolling children in public programs while parents participate in the exchange.³⁹

At the same time, approaches that use Medicaid plans to cover all residents up to 200 percent FPL could improve continuity of coverage and care and reduce "churning." With the income threshold for transitioning between public programs and

the exchange set at 133 percent FPL, more than 35 percent of all low-income adults will need to change between Medicaid and the exchange at least once every six months.⁴⁰ For two reasons, raising the income threshold to 200 percent FPL would reduce the number of subsidy recipients moving between programs. First, many more people will qualify for subsidies at lower income levels, where ESI offers are less frequent.⁴¹ Second, significant income volatility is more widespread at lower income levels,⁴² where unstable and shifting employment arrangements are more common.

Continuity will be greatly shaped by how a state implements BHP. If a state covers adults through health plans that do not overlap with Medicaid—for example, if a state enrolls adults in a separate CHIP program that uses non-Medicaid plans—continuity might not improve and could even worsen. Conversely, a state that uses the “two-way bridge” approach described earlier would maximize consumers’ ability to achieve continuous coverage and care.

On a different front, many consumers would experience a serious disadvantage if a state used BHP to extend existing public programs to additional low-income adults—namely, they would typically have much more limited access to providers than they would enjoy in the exchange. In most states, Medicaid pays low reimbursement rates that greatly limit participation by many types of providers.⁴³ Provider payment levels, hence participation problems, could easily worsen during the next few years as states continue to grapple with severe budget deficits.⁴⁴

On the other hand, if federal BHP payments turn out to exceed baseline Medicaid costs, the excess could be used to raise capitated payments and provider reimbursement above Medicaid levels, without spending state general fund dollars.⁴⁵ Using any such excess in this way would help a state meet the statutory requirement that federal BHP payments must be spent on BHP members.⁴⁶

Even if federal funding through BHP does exceed baseline Medicaid costs by a margin consistent with current private markets, using the additional dollars to raise reimbursement rates is unlikely, in most states, to replicate fully the breadth of provider networks offered by typical commercial insurance. Nevertheless, as in some CHIP programs, access to care could exceed that provided by Medicaid.

More generally, if low-income consumers receive BHP through the plans and providers currently serving Medicaid and CHIP, they will lose access to some private plans in the exchange. However, BHP may preserve consumers’ access to “safety net” plans and affiliated providers that, in the past, specialized in serving low-income communities through Medicaid and CHIP but that may not be offered in the exchange.⁴⁷ If a state implements BHP along the lines discussed here, plans experienced in working with low-income communities could continue doing so with low-income consumers whose incomes exceed Medicaid levels.

One final consumer issue is important. BHP, like subsidies in the exchange, is limited to individuals without access to affordable, comprehensive ESI, as explained above. Medicaid eligibility does not impose that limitation. If adults with incomes above 133 percent FPL lose Medicaid, those offered affordable, comprehensive ESI will become ineligible for federally funded subsidies, whether or not their state implements BHP.

Issues for states

Budget savings

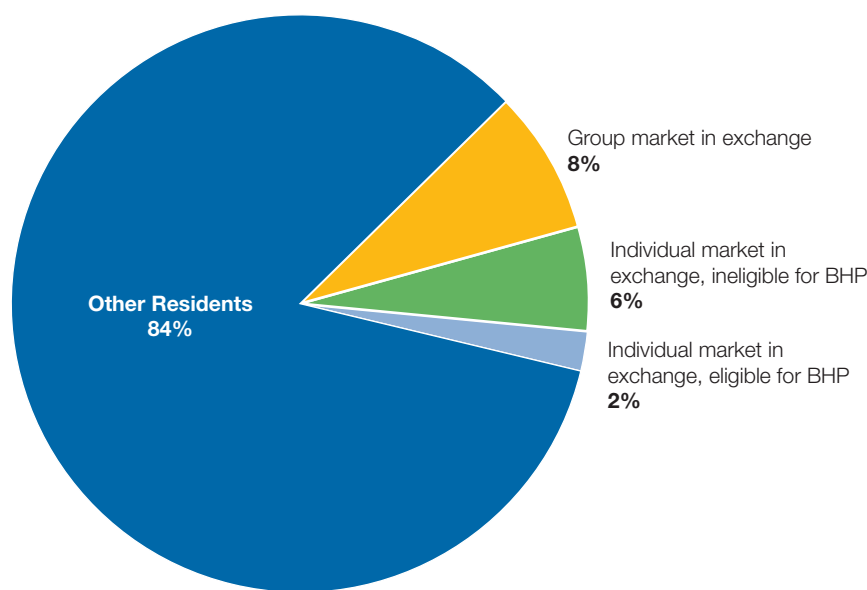
Using BHP to provide low-income adults with coverage similar to that furnished by Medicaid or CHIP would let states terminate optional Medicaid coverage for adults with MAGI above 133 percent FPL, without increasing such adults’ health care costs or cutting their benefits. For example, pregnant women in most states receive Medicaid up to at least 185 percent FPL.⁴⁸

Federal Medicaid law forbids charging such women premiums or OOP cost-sharing for pregnancy-related services. If these women lose Medicaid and shift to the exchange, the state would save money, but the women would be charged more and might receive less prenatal care. If such women instead were covered through BHP, the state would save the same amount by terminating their Medicaid eligibility, but BHP coverage could be structured to shield affected women from increased costs.⁴⁹

Similar results apply in states that, today, cover parents (or other non-elderly adults) with MAGI between 133 and 200 percent FPL. When Connecticut developed its above-described proposal for BHP implementation, for example, Dr. Jonathan Gruber of the Massachusetts Institute of Technology projected that it would save approximately \$50 million a year in general fund expenditures for Medicaid-eligible parents without increasing their premiums or OOP costs and without reducing benefits.⁵⁰

Medically needy coverage provides an additional opportunity for state savings, one that does not involve cutting back eligibility.⁵¹ Offered in most states, medically needy programs cover a combination of long-term care, catastrophic medical expenses, and chronic care after a beneficiary incurs a certain level of health care costs (“spend-down”).⁵² Under ACA, medically needy, non-elderly adults between 133 and 200 percent FPL will receive comprehensive coverage through the exchange. This will save money for medically needy programs, as formerly uninsured adults will take longer to meet Medicaid spend-down requirements. However, to increase such savings by further delaying the point when such requirements are met, a state could implement BHP to lower OOP costs below levels in the exchange and to cover some long-term care services that fall outside traditional private insurance.⁵³

Figure 3. Among non-elderly U.S. residents, projected coverage through health insurance exchanges under full ACA implementation, by insurance market and potential BHP eligibility



Source: Urban Institute, 2010.⁵⁴ Notes: This figure shows the effects of national ACA implementation (hence, ACA implementation in the average state) based on HIPSM estimates. It classifies people as BHP-eligible if they have modified adjusted gross income at or below 200 percent FPL and, without BHP, they would receive subsidized, individual coverage in a health insurance exchange.

Exchange size

If a state implements BHP, fewer individuals will be covered through the exchange. Urban Institute microsimulations of the effect of ACA suggest that, in the average state, BHP implementation would reduce from 8 to 6 percent the proportion of non-elderly residents receiving individual coverage through the exchange (Figure 3). With exchange group markets projected to reach an additional 8 percent of non-elderly residents, BHP will reduce total enrollment in the average exchange from 16 to 14 percent of all residents.

Such shrinkage should not imperil exchanges. For example, the Massachusetts commercial exchange, Commonwealth Choice, has been stable with fewer than 40,000 enrollees, or less than 1 percent of the state's non-elderly population.⁵⁵ Inapplicable to ACA, which resembles the Massachusetts reform law, are suggestions that as many as 100,000 covered lives are needed for exchange viability. Jost explained this concern as follows:

“Small insurance pools, being potentially volatile and susceptible to destabilization by large claims, are

problematic for insurers. According to one expert view, a risk pool of at least 100,000 covered lives would probably be necessary to be viable.”

Under ACA, an insurer serving the individual market must pool all of its enrollees both inside and outside the exchange. It is this combined risk pool, not exchange participants alone, that must have the stability insurers require before they will offer coverage. Jost continued:

“If insurers cover a number of lives outside of the exchange, however, the size of the pool offered by the exchange may be less important. Moreover, once risk-status underwriting is eliminated, a universal insurance-purchase mandate goes into effect, and reinsurance and risk adjustment are implemented, the risk faced by a single plan will be considerably diminished”⁵⁶

On the other hand, if an exchange spreads fixed administrative costs over a smaller pool of enrollees, costs per enrollee rise. Any resulting premium increase would mainly affect federal costs, but it could also increase amounts that non-subsidized consumers⁵⁷ (and perhaps employers) pay in the exchange. In addition, implementing

BHP could decrease an exchange's leverage to improve quality, lower premiums, and achieve goals such as reforming health care delivery, increasing portability, improving consumer information, and holding insurers accountable.⁵⁸

Leverage would play out differently in a state that lowers spending by coordinating its purchasing of services through multiple state-administered programs. Adding BHP-covered lives to state employee insurance, Medicaid, CHIP, mental health services, health care for prisoners, and so forth could modestly increase such a state's ability to lower prices and improve quality across the full range of state-purchased care. Instead of trimming federal subsidies, the leverage provided by BHP-eligible covered lives could reduce state costs.

Still other states may combine all covered lives, both in the exchange and state-purchased coverage, to encourage reforms. For example, a state interested in interoperable electronic health records could require specified levels of performance from any health plan or provider that seeks to participate in either the exchange or state-purchased coverage. Such a state's leverage to accomplish these goals would not be affected by whether adults with incomes between 133 and 200 percent FPL are covered through state-purchased BHP coverage or the exchange.

Risk

If a state implements BHP, the risk pool in the exchange's individual market may change as its lowest-income members depart. The precise nature of that change will depend on state demographics, of course. But it will also depend on state policy decisions. Based on previous Urban Institute microsimulations of ACA's national effects,⁵⁹ BHP implementation would likely affect the exchange's risk pool in the average state as follows:

- If a state combines the small group and individual markets, the size of the exchange would grow to the point that implementing BHP would probably have little effect.

- In a state that does not combine those markets:
 - If the state preserves existing Medicaid coverage for adults with income above 133 percent FPL, health care costs will be lower for BHP members than for other individuals in the exchange because BHP members will tend to be younger. As a result, implementing BHP could modestly raise the average cost of individual coverage in the exchange.
 - If the state shifts non-elderly adults above 133 percent FPL out of Medicaid, BHP would include some pregnant women and people with disabilities who formerly qualified for Medicaid.⁶⁰ As a result, implementing BHP could either leave unchanged or slightly reduce the average cost of adults receiving individual coverage in the exchange.

Risk effects in either direction should not be exaggerated. As noted, ACA requires each insurer to pool all of its individual market enrollees. If BHP members are healthier than average and leave the exchange, costs will rise in the remaining individual market as a whole. The resulting increase in average costs will be less than if BHP's impact were absorbed by the exchange alone.

Such effects might be avoided entirely if states enact policies that share risk among BHP plans and the individual market. Depending on how HHS interprets ACA, a state might be able to use its regulatory authority to subject a state-licensed insurer that operates a BHP plan to the same rules that govern the individual market. That would require such an insurer to pool BHP enrollees with its other customers in the individual market. In addition, whether or not a BHP plan is sponsored

by a state-licensed insurer, a state might be able to include the plan in its risk-adjustment and reinsurance systems.⁶¹ Under that approach, a BHP plan with lower average risk levels than the rest of the individual market would make payments accordingly, thus lowering the burden borne by other individual market plans. If BHP enrollees turn out to be sicker than the average individual market enrollee, BHP plans would receive risk-adjustment and reinsurance payments that make up the difference. If such a policy is allowed by HHS and achieves its goals, BHP implementation should not affect the overall risk level of the individual market because it would simply move consumers between plans that share risk together.

Conclusion

In some ways, this paper's analysis is necessarily tentative. State decisions about whether to implement the BHP option will be affected by guidance the federal government has not yet issued to interpret ACA. The characteristics of each individual state will also be important in shaping the impact of BHP on both consumers and state government. That said, it is clear, even at this early stage, that the BHP option deserves serious consideration by states seeking to provide their low-income residents with affordable and continuous coverage while improving state fiscal circumstances in 2014 and beyond.

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Endnotes

- 1 ACA §1331(d)(2).
- 2 Another potential source of administrative dollars for BHP is some of the funding that otherwise would have covered exchange administration.
- 3 It is not completely clear whether states have the option to extend BHP to some but not all individuals described in the statute. While this is one of many issues that will need to be resolved by the U.S. Department of Health and Human Services (HHS), the most direct reading of the statutory language is that a state implementing the BHP option must cover all individuals who meet the four criteria listed in the text. See ACA §1331(a)(1) and (e).
- 4 Another question requiring HHS interpretation is whether, in applying the 200 percent FPL cut-off, the same method is used to calculate income as applies to Medicaid; that is, will 5 FPL percentage points be subtracted from Modified Adjusted Gross Income (MAGI)? Presumably, at the lower-income bound for BHP eligibility, the same method will apply as defines the upper-income bound of Medicaid eligibility. It is not clear whether a different approach will apply at the upper-income bound for BHP.
- 5 This is the same “ESI firewall” that limits eligibility for tax credits and other subsidies in the exchange. Put differently, a consumer may neither receive BHP nor qualify for subsidies in the exchange if he or she is offered ESI that has (1) a worker premium cost at or below 9.5 percent of family income and (2) an actuarial value of 60 percent or more.
- 6 In states that set the upper limit for CHIP eligibility below 200 percent FPL, BHP could cover children with incomes that are between the CHIP limit and 200 percent FPL.
- 7 In addition, for purposes of ACA, “lawful presence” includes some immigration status categories that fall outside those permitted under most types of federally matched Medicaid eligibility.
- 8 It is not completely clear how such CHIP children would be treated if federal funding is not renewed. The Social Security Act §2105(d)(3)(B), added by ACA §2101(b), says that when a state’s CHIP allotments have run out “the State shall establish procedures to ensure that the children [who qualify for a separate CHIP program] are enrolled in a qualified health plan that has been certified by the Secretary” to offer benefits and out-of-pocket cost-sharing like that formerly offered by CHIP. This provision raises many questions. For example, may a family enroll a child in the same plan that serves the parents through the exchange, in which case the child would likely receive less generous coverage than under CHIP? If the child is enrolled in an HHS-certified plan, must the family pay the full difference in premium between that plan and the second-lowest-cost “silver” plan, to which premium subsidies are pegged? (Silver plans have an AV of 70 percent.) If a CHIP-eligible child has access to affordable, comprehensive ESI, is the child barred from subsidized coverage in the exchange? And what happens if a state’s exchange offers no HHS-certified plan?
- 9 This analysis presumes that the consumer receives all available subsidies and enrolls in the second-lowest-cost “silver” plan, which is the benchmark to which tax credits are pegged.
- 10 The statute may be read in two ways: either (1) BHP consumers may not receive coverage with an AV below the level they would receive in the exchange; or (2) at or below 150 percent FPL, BHP consumers may not receive coverage below the platinum level and, above 150 percent FPL, BHP AV may not fall below the gold level. Compare §1331(a)(2)(A)(ii) (platinum and gold AV) with the unnumbered language at the end of §1331(a) (premium determined after reduction for “any premium tax credits and cost-sharing reductions allowable with respect to either [BHP or the second-lowest-price silver value plan in the exchange]”).
- 11 ACA §1331(c)(2)(C).
- 12 In a related variant, some Medicaid programs combine fee-for-service payment with a “patient-centered medical home” through which a primary care provider may (either directly or by working with a community health team) perform functions that include care coordination and patient education. After implementing such an approach, North Carolina’s Medicaid experienced significant cost savings and quality gains. Samantha Artiga, *Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid*, Kaiser Commission on Medicaid and the Uninsured, May 2009.
- 13 ACA §1331(b)(2)(A).
- 14 ACA §1331(c)(3)(A).
- 15 Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2011 to 2021*, January 2011.
- 16 From 1990 through 2008, private insurance premiums per capita rose, during the median year, by 6.1 percent, whereas personal income grew by 5.5 percent. Author’s calculations from CMS Office of the Actuary, *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2008 to 1960*; Bureau of Economic Analysis, U.S. Department of Commerce, “Personal Income and its Disposition,” *National Income and Product Accounts Table*, last revised on January 28, 2011.
- 17 Medicare and Medicaid Extenders Act of 2010, P.L. 111-309, amending IRS §36B(f)(2)(B). For adults filing individual returns, maximums are 50 percent of the amounts shown in the text.
- 18 Chris L. Peterson, *Setting and Valuing Health Insurance Benefits*, Congressional Research Service, April 6, 2009. The description in the text does not include out-of-pocket cost-sharing limits because the discussion focuses on the initial deterrent effect of cost-sharing on utilization of care, not on the cumulative financial burden of cost-sharing.
- 19 See, e.g., Katherine Swartz, *Cost-sharing: Effects on Spending and Outcomes*, Research Synthesis Report No. 20, Robert Wood Johnson Foundation, December 2010; Julie Hudman and Molly O’Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, March 2003; Bill J. Wright, Matthew J. Carlson, Heidi Allen, Alyssa L. Holmgren, and D. Leif Rustvold, “Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out,” *Health Affairs*, December 2010; 29(12):2311–2316; Dana P. Goldman, Geoffrey F. Joyce, and Yuhui Zheng, “Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health,” *Journal of the American Medical Association*, July 4, 2007; 298(1):61–69; Becky A. Briesacher, Jerry H. Gurwitz, and Stephen B. Soumerai, “Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature,” *Journal of General Internal Medicine*, June 2007; 22(6):864–871; Samantha Artiga and Molly O’Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences*, Kaiser Commission on Medicaid and the Uninsured, May 2005.
- 20 E.g., Sharon K. Long and Paul B. Masi, “Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008,” *Health Affairs*, Web Exclusive, May 28, 2009; w578–w587; Sharon K. Long and Karen Stockley, “Sustaining Health Reform in a Recession: An Update on Massachusetts as of Fall 2009,” *Health Affairs*, June 2010; 29(6):1234–1241.
- 21 Massachusetts Commonwealth Connector, *Member Monthly Premium*, 2010, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Connector%2520Programs/Benefits%2520and%2520Plan%2520Information/Enrollee_Contributions.pdf.
- 22 Joanna Stamatiades and James Cook, GAO, Eric Larson, Internal Revenue Service, *Demographic and Noncompliance Study of the Advance EITC (AEITC)*, Presented at the 2008 IRS Research Conference, June 11, 2008; Government Accountability Office, *Advance Earned Income Tax Credit: Low Use and Small Dollars Paid Impede IRS’s Efforts to Reduce High Noncompliance*, GAO-07-1110, August 2007. As with ACA, the EITC statute limits the size of possible tax debts to IRS, although it does so by capping the amount of the EITC that may be paid in advance rather than by limiting the amount subject to reconciliation. Factors other than reconciliation, including workers’ desire for year-end tax refunds, are also important in deterring use of the advance EITC.
- 23 Jack Hadley and John Holahan, “Is Health Care Spending Higher under Medicaid or Private Insurance?” *Inquiry*, Winter 2003/2004; 40(4):323–342.
- 24 The Urban Institute estimates described in this report are based on the Health Insurance Policy Simulation Model (HIPSM), which uses national survey data and economic analyses of individual and business behavior to examine how employer-sponsored insurance, private non-group coverage, and Medicaid and CHIP are likely to change in response to policy modifications. For a description of HIPSM, see Urban Institute Health Policy Center, *The Urban Institute’s Health Microsimulation Capabilities*, July 19, 2010, www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf.
- 25 According to the Medical Expenditure Panel Survey Household Component (MEPS-HC), average health care costs in 2008 among adults obtaining any health care were \$2,277 for adults ages 19 to 24, \$2,818 at ages 25 to 34, \$3,508 at ages 35 to 44, \$4,460 at ages 45 to 54, and \$7,402 at ages 55 to 64. At the same time, the percentage of adults using care ranged from 70 percent at ages 19 to 24 to 92 percent at ages 55 to 64. Data tables may be accessed at www.meps.ahrq.gov.

- 26 HIPSM projects that, in the exchange, premiums could differ from those charged for comparable coverage today because of factors such as administrative efficiencies, risk pool changes, and ACA insurance reforms. But HIPSM does not include the type of premium savings that would result from substituting Medicaid plans for typical private insurance, aggressive negotiation by the exchange that lowers premiums by a substantial percentage, delivery system and payment reforms that have a dramatic effect on cost growth, and so forth.
- 27 Of course, the decision about whether to encourage Medicaid plans to offer coverage in the exchange involves many factors other than BHP implementation. Such participation in the exchange would give families the option to keep the same health plan when they shift between Medicaid and the exchange, thereby promoting continuity of coverage and care. On the other hand, including inexpensive Medicaid plans in the exchange could, by lowering the reference premium, make it more costly for tax credit beneficiaries to enroll in standard commercial insurance. In addition to making an income-based payment, beneficiaries choosing a plan more costly than the reference plan must pay the full difference in premiums.
- 28 If private premiums in the exchange fall, the federal government will achieve savings, but state government will be unaffected, as will most subsidy recipients. As noted elsewhere in this paper, consumer premium costs will be based on income if they avoid plans more costly than the reference plan. In addition, unsubsidized individual enrollees in the exchange would benefit from lower premiums, as would employers in a state that merges the small group and individual markets.
- 29 Internal Revenue Code §36B(a)(3)(A)(ii), added by ACA §1401(a). After 2018, if the total national volume of tax credits and OOP cost-sharing subsidies exceeds a specified percentage of the Gross Domestic Product during a year, the following year's indexing of tax credits will be based on the Consumer Price Index rather than on income growth.
- 30 Annual Medicaid cost increases per enrollee averaged 4.8 percent from 2000 through 2007. John Holahan and Alshadye Yemane, "Enrollment Is Driving Medicaid Costs--But Two Targets Can Yield Savings," *Health Affairs*, September/October 2009; 28(5):1453–1465. Over that same period, national income rose by an average of 3.64 percent per year. Author's calculations, U.S. Census Bureau, *Current Population Survey, Annual Social and Economic Supplements, 2001–2008*, March 2010. If those same trends continue and federal BHP payments were indexed to income, then the difference between federal BHP payments and Medicaid costs shown in Figure 2 would gradually shrink with each passing year, finally converging in 24 years. If unindexed cost-sharing subsidies raised the annual increase in federal BHP payments by just one-tenth of 1 percentage point above changes to national income, BHP payments would exceed Medicaid costs for 26 years.
- 31 A "look-alike" approach is required for both Medicaid and CHIP because ACA §1331(b)(1) forbids BHP plans from serving non-BHP consumers. Just as some states used a "Medicaid look-alike" approach for CHIP separate programs, through which CHIP children received Medicaid benefits and cost-sharing and enrolled in the same health plans that served Medicaid children—albeit with CHIP rather than Medicaid federal funds and without an individual entitlement—so too a "look-alike" approach here would serve BHP enrollees through Medicaid health plans offering Medicaid benefits and OOP cost-sharing but with different underlying federal payments and governing statutes.
- 32 A state with fee-for-service Medicaid could extend such coverage to BHP adults, using the same covered benefits and cost-sharing limitations that apply to Medicaid.
- 33 Jane Beyer, personal correspondence, November 2010. In fact, ACA's BHP provisions encourage such steps. See ACA §1331(c)(2)(A).
- 34 This is shorthand for the following rules: (1) ESI receipt does not end Medicaid eligibility, although when a Medicaid beneficiary has ESI, Medicaid becomes the secondary insurer; (2) Medicaid and CHIP eligibility is unaffected by an individual's rejection of an ESI offer (with certain exceptions that apply to CHIP children offered ESI by public employers); but (3) BHP eligibility is limited to people who are either (a) not offered ESI or (b) have ESI offers that fail to meet ACA requirements of affordability and comprehensiveness, as explained earlier.
- 35 Section 1331(f)(1) requires BHP members to go through the same verification process that applies to subsidies in the exchange, which should help with such "back room" sorting.
- 36 The approach proposed in Connecticut would extend that state's HUSKY program to 200 percent FPL for all adults; under current law, parents are covered up to 185 percent FPL. For all adults, cost-sharing and benefits would be identical to those provided by Medicaid. Children up to 300 percent FPL would continue to be covered through HUSKY, using a combination of funding through Title XIX and Title XXI of the Social Security Act. This proposal would not reduce adults' benefits or increase their costs as income rises above 133 percent FPL. See *Report to the Connecticut General Assembly from the Sustinet Health Partnership Board of Directors* (Sustinet Report), January 2011, www.ct.gov/sustinet/lib/sustinet/sn.final_report.cga.010711.pdf.
- 37 One problem with this approach is that the additional premium charged in the exchange could perhaps count against an insurer in calculating its compliance with Medical Loss Ratio (MLR) requirements. A state might be able to get around this problem by (1) supplementing BHP dollars so that the total state payment equals what the federal government would have provided in the exchange and (2) funding such supplement by levying a fee on plans offered in the exchange. Under interim final regulations issued by HHS, certain state taxes and assessments may be subtracted from premiums in determining insurers' MLR. See 45 CFR §158.161(b)(1) in *Federal Register* 75(230): 74864–74934, December 1, 2010.
- 38 Year-end reconciliation would change the flow of funds from the federal government to states. However, under the approaches to BHP that are the focus of this paper, low-income families would not be required to make year-end payments based on income changes throughout the year. Rather, such changes could be addressed as under Medicaid and CHIP.
- 39 Beyond administrative efficiencies for the state and increased convenience to families, the benefits of a single health plan for all family members may not be great. Often, adults and children are served by different provider networks, even within the same plan. And while research shows that, when parents receive health insurance, children are more likely to enroll in coverage and obtain care, no published studies show any measurable gains when parents and children receive the same health insurance (as opposed to health coverage through different plans). Amy Davidoff, Lisa Dubay, Genevieve Kenney, and Alshadye Yemane, "The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children," *Inquiry*, Fall 2003; 40(3):254–268; Lisa Dubay and Genevieve Kenney, "Addressing Coverage Gaps for Low-Income Parents," *Health Affairs*, March/April 2004; 23(2): 225–234.
- 40 Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges," *Health Affairs*, February 2011; 30(2):228–236.
- 41 Lisa Clemans-Cope and Bowen Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005*, prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, December 2006.
- 42 Neil Bania and Laura Leete, *Income Volatility and Food Insufficiency in U.S. Low Income Households, 1991–2003*, draft paper prepared for presentation at the USDA/National Poverty Center Conference: Income Volatility and Implications for Food Assistance Programs—II, November 16–17, 2006, Economic Research Service, U.S. Department of Agriculture, October 2006.
- 43 E.g., Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends in Medicaid Physician Fees, 2003–2008," *Health Affairs*, May 2009; 28(3):w510–w519.
- 44 It is true that, for 2013 and 2014, ACA provides 100 percent federal funding for the cost of raising Medicaid payments to Medicare levels for evaluation and management services furnished by primary care providers. It is also true that ACA increases the total capacity of community health centers. In addition to increasing appropriations for such centers, ACA reduces the burden of uncompensated care on community clinics, and health centers are likely to garner additional revenue from ACA's requirement that all plans participating in the exchange must contract with health centers and pay them cost-based reimbursement. That said, with ACA's maintenance-of-effort requirements preventing eligibility reductions in Medicaid and CHIP, many states facing severe budget shortfalls are likely to cut Medicaid provider payments further. Moreover, starting in 2014, a major new influx of Medicaid adults will begin demanding services from an already overburdened network of Medicaid-participating providers.

- 45 In addition, a state could, through two steps, raise the amount of reimbursement received by providers, given a fixed per member per month (PMPM) amount paid to health plans: first, increasing OOP cost-sharing slightly above Medicaid amounts would reduce claims volume, thus allowing higher average payment per claim; and, second, raising medical loss ratios would increase total provider payments for a given PMPM.
- 46 Because of this federal requirement, BHP dollars could not be used to raise Medicaid reimbursement rates for all enrollees; the increase would need to be limited to BHP consumers, even though their income will be higher than that of most Medicaid beneficiaries. To boost payments for providers serving Medicaid beneficiaries, a state would need to use Medicaid dollars.
- 47 ACA apparently requires a plan in the exchange's individual market to be offered to all enrollees, including those with incomes too high for subsidies. See ACA §§1311(d)(2)(A) and §1312(f)(1). For a discussion of the operational and mission-related challenges that participation in the exchange would pose to Medicaid/CHIP safety net plans, see Walter A. Zelman, *Community-Based Nonprofit Medicaid Plans and the New Health Insurance Exchanges: Opportunities and Challenges*, State Coverage Initiatives, October 2010.
- 48 Donna Cohen Ross, Marian Jarlenski, Samantha Artiga, and Caryn Marks, *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents during 2009*, Center on Budget and Policy Priorities and Kaiser Commission on Medicaid and the Uninsured, December 2009.
- 49 For women with incomes above 200 percent FPL, for whom BHP is not available, a state could limit OOP costs that plans in the exchange may charge for maternity care services received by pregnant women who would have qualified for Medicaid under rules in effect before ACA. While such a state would pay the resulting increase in federal subsidies, those expenses would be lower than the state's share of all Medicaid costs for the affected pregnant women.
- 50 Of course, the state could achieve equivalent savings by terminating the parents' Medicaid coverage and moving them into the exchange. But that would reduce these adults' benefits and increase their costs, without saving any additional money for the state. SustiNet Report, op cit.
- 51 This analysis assumes that, to preserve current access to long-term care by non-elderly people with disabilities, states will continue medically needy eligibility.
- 52 For information about one state's medically needy coverage, see California HealthCare Foundation, *Share of Cost Medi-Cal*, September 2010.
- 53 As another example of cost savings, some states could reduce their spending on the coverage they provide to poor and near-poor immigrants who received satisfactory immigration status within the past five years. A state that currently uses state and local dollars to cover such immigrants could continue to furnish them with Medicaid-type coverage under BHP while shifting the cost of their coverage to the federal government. Likewise, a state that, today, extends optional Medicaid coverage to pregnant women within the first five years after they receive satisfactory immigration status could, without eliminating any benefits or cost-sharing protections, end these women's Medicaid eligibility and have the federal government pay for their coverage via BHP. Of course, such a state could achieve equivalent savings by terminating its current coverage for these immigrants and shifting them into federally subsidized coverage in the exchange, but doing so would raise their premiums and OOP costs without providing any additional state savings.
- 54 Matthew Buettgens, Bowen Garrett, and John Holahan, *America under the Affordable Care Act*, prepared by the Urban Institute for the Robert Wood Johnson Foundation, December 2010.
- 55 Massachusetts Commonwealth Connector, op cit.; Massachusetts Commonwealth Connector, *Report to the Massachusetts Legislature, Implementation of the Health Care Reform Law, Chapter 58, 2006-2008*, October 2, 2008; U.S. Census Bureau, *State & County QuickFacts: Massachusetts*, last revised August 16, 2010. While Commonwealth Choice has grown over time and its stability is unquestioned, some observers have been disappointed by the program's small size, believing that an exchange with more covered lives could have a more significant impact on the state's health insurance markets.
- 56 Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, prepared by Washington and Lee University School of Law for The Commonwealth Fund, July 2010. While, as Jost notes, an insurer must have enough covered lives to obtain favorable rates from providers, a plan could condition access to all of its enrollees on provider agreement to accept specified reimbursement levels. At the same time, plans selling coverage both within and outside the exchange could offer the same provider network to all enrollees, just as many insurers do today in leveraging their existing provider networks to gain new business.
- 57 As explained earlier, a subsidized consumer typically pays premiums based on two factors: (1) household income and (2) the difference between premiums for the consumer's plan and premiums charged by the second-lowest-cost plan with silver actuarial value. If premiums rise by the same amount for all individual market plans in the exchange, the federal government will pay more in tax credits, but most subsidized consumers will be unaffected.
- 58 Stan Dorn, *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals*, prepared by the Urban Institute for State Coverage Initiatives, updated September 3, 2010, www.statecoverage.org/files/SCL_Dorn_Report_2010_Updated_9.3.2010.pdf.
- 59 These are preliminary conclusions. Further modeling would be required to yield conclusive estimates.
- 60 Some former Medicaid eligibles would have MAGI above 200 percent FPL and would therefore qualify for subsidies in the exchange rather than for BHP. However, BHP would pick up most adults who lose Medicaid coverage because of MAGI above 133 percent FPL.
- 61 Unlike ACA's risk-adjustment and reinsurance mechanisms, the legislation's risk-corridor program is federally administered. States may thus have less ability to shape the latter program, which seeks to guard against unforeseen spikes in claims rather than the concentration of prospectively identifiable, high-risk consumers in a single plan. A state could pursue the risk-corridor program's goals through other methods if HHS bars some BHP plans from participation (and after the temporary risk-corridor program ends). For example, a state could require BHP premiums to include funding for stop-loss coverage.